and the nonprofit sector, dedicated to increasing private investment in low-income communities, both rural and urban. To achieve this mission, they lead by example, recognizing successful and innovative partnerships between financial services institutions and neighborhood nonprofit organizations that are working together to reclaim vulnerable neighborhoods. As a result of the Outstanding Community Investment Awards, DeSales Community Housing and Equality Savings were chosen out of 160 applicants as a model partnership.

DeSales and Equality are being recognized for the creation of the DeSales Mutual Housing Association. This kind of development represents the first step toward home ownership for life-long renters. Mutual housing associations encourage community-based ownership of affordable rental properties. Neighborhood residents and project tenants actively participate in ownership and management decisions of their buildings, including site selection, design, construction, and organizational structure.

DeSales began working with residents on the mutual housing association model in the early 1990's. Today, thanks to the dedication of 30 neighborhood residents, the Iowa Avenue Townhouses and the California Townhouses have taken the place of nine vacant buildings in south St. Louis as models of affordable, resident-controlled housing.

Equality Savings and Loan Association assumed a critical leadership role in making this project happen. The small thrift took charge of convincing the financial community, businesses, foundations, and the major's office of the credibility of the project. Equality also helped enlist additional investors to provide permanent financing and, equally important, they convinced St. Louis residents and others that this innovative approach could work.

Thanks to the first mutual housing association model ever enacted in Missouri, neighborhood residents are taking on leadership responsibilities in their community. Small-scale rehabilitation is happening elsewhere, and the community's church and elementary school are crediting the townhomes for stabilizing their surroundings.

I applaud DeSales Community Housing Corporation and Equality Savings and Loan Association as a replicable example of a public private partnership that empowers residents to reclaim their neighborhoods.

MEDICAL SAVINGS ACCOUNTS—DISABLED COMMUNITY EXPLAINS WHY THEY ARE A PROFOUNDLY BAD IDEA

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 6, 1995

Mr. STARK. Mr. Speaker, medical savings accounts are a brilliant scheme to skim the healthiest people out of the insurance pool—and leave the rest of us to face sky-rocketing insurance rates. MSA's are a bad idea that has spread like wildfire.

Following is a portion of the testimony of the Consortium for Citizens With Disabilities before the Ways and Means Subcommittee on Health on May 25. I hope the CCD's insights will help stop this lemming-like pursuit of MSA legislation.

MEDICAL SAVINGS ACCOUNTS

Many Members of Congress believe that Medical Savings Accounts (MSAs) have the potential to reduce health care costs and increase the number of Americans with insurance. There have been suggestions that MSAs be implemented not only in the private sector but in the Medicare program as well.

The Consortium for Citizens with Disabilities Health Task Force has major concerns with the emphasis presently being placed on Medical Savings Accounts as a solution to our health system's problems of access and affordability. The use of MSAs is not only untested, but also has the very strong potential for making comprehensive health insurance less affordable for persons with disabilities and serious chronic illnesses. Because of our many concerns, which are discussed below, and in the absence of other reforms, the CCD Health Task Force does not support the establishment of MSAs as either an incremental reform or as a solution to the health care problems facing millions of uninsured and underinsured individuals in the U.S.

Supporters of MSAs state that:

MSAs will allow the marketplace, not the government to address the cost and access issue. By giving responsibility for paying for health care to consumers, it is assumed that MSAs will reduce unnecessary health care expenditures because individuals who are spending their own money will be more prudent purchasers. It is also assumed that the lower cost of catastrophic health insurance will lead more employers to offer the health insurance.

MSAs will lead to lower administrative costs because insurance companies will only be involved with claims higher than the deductible amount.

However, MSAs are untested, and it is not clear that they will either lower costs or improve access to services.

What are MSAs and How do they Work?

Medical Savings Accounts are tax-exempt savings accounts modeled on Individual Retirement Accounts that employed individuals can use to pay for health-related expenditures. State MSA laws generally create incentives for people to set up these accounts by exempting from state taxes the money contributed to these accounts. MSAs work like this:

Employers can purchase a standard health insurance plan with a low deductible ($250–$500 annually per person) or a catastrophic health insurance plan with a high deductible ($3000–$5000 annually per person). Because most people will not have health care costs higher than several thousand dollars, the premiums for high deductible catastrophic health insurance plans are much lower than for plans with low deductibles.

An employer sets up a MSA for employees who want to participate in this type of plan and deposits, in pre-tax dollars, an amount equal to the difference between the cost of a standard low deductible plan and a catastrophic high deductible plan. The self-employed can also set up a MSA.

Employees can use the money in their individual account for health care expenses. When the high deductible is met, the insurance company then pays the bills. If money is left in the account at the end of the year, it can be withdrawn and used for other purposes or carried over with accrued interest into the next year.

The CCD has several major concerns about MSAs:

The catastrophic health plans that are purchased in conjunction with MSAs can impose pre-existing condition limitations and can refuse to cover persons with certain health conditions or disabilities.

Catastrophic health plans with high deductibles often do not provide the comprehensive coverage needed by persons with serious illnesses or conditions. Some of these plans have lifetime or per condition limits of only $100,000.

The American Academy of Actuaries has estimated that persons with high health expenses will experience major increases in out-of-pocket costs with MSAs. MSAs may also increase out-of-pocket costs if the amount employers contribute to the MSA is not sufficient to cover the annual catastrophic deductible. Additionally, the combined cost to the employer of an MSA contribution and the catastrophic health plan premium may not be less than the cost of a standard health plan.

If large numbers of individuals choose MSAs plus catastrophic health plans, the health insurance market will be further segmented, reducing the size of the population pool needed to spread risk adequately.

MSA will likely lead to adverse selection because they will be utilized primarily by younger, healthier people who do not anticipate a need for health care. Persons who anticipate health care expenditures, those who need comprehensive coverage, and those who are older and at higher risk for needing health care are likely to remain in standard low deductible health insurance plans. Individuals with MSAs could also change to a low-deductible plan when they become sick or anticipate medical bills (e.g., childbirth expenses), thus exacerbating the problem of adverse selection.

Adverse selection will lead to higher premiums for persons in standard, low deductible health insurance plans. It has been estimated that if MSAs are widely adopted, the cost of a standard, low deductible health insurance policy would rise by as much as 26%. Increases of this magnitude will make comprehensive, low deductible insurance unaffordable both for employers and individuals who want to purchase these policies.

There is no evidence that MSAs will make consumers more cost conscious when they are seriously ill. Physicians—not consumers—determine what treatment is needed. If surgery is recommended, consumers don't look for the cheapest surgeon, they look for the best surgeon.

Some individuals may forgo preventive and early intervention services if they are allowed to use money left in their MSAs at the end of the year for personal expenses other than health care. This concern also raises the question of whether it is appropriate to allow pre-tax dollars to be used for non-health expenses.

It is likely that catastrophic health plans will restrict the type of health care expenditures that will count towards the deductible. For example, if an individual spends $3000 on mental health services, there is no guarantee that all of these expenses will be counted towards the deductible, particularly if the insurance has limited coverage for these services.

A majority of Americans are enrolled in some form of managed health care plan. It is unclear whether MSAs can be coordinated with these plans. Those opposed to managed care view MSAs as a means to maintain the market for indemnity insurance and fee-for-service health care delivery.

Experience with MSAs is very limited. It is not clear whether they will result in savings. Some analysts predict that any potential system cost savings will be eliminated by the additional costs required to administer MSAs.

Most importantly, the CCD Health Task Force believes that allowing employers and the self-employed the option of establishing tax deductible MSAs in conjunction with

high deductible catastrophic insurance coverage is not the solution to our nation's health system problems because:

MSAs do not address the need for insurance by millions of working Americans whose employers will not contribute to the cost of health insurance; and

MSAs do not address the need for insurance by millions of low-income individuals who are self-employed or unemployed and who cannot afford to buy health insurance.

THE ADVANCED MEDICAL DEVICE ASSURANCE ACT OF 1995

HON. WILLIAM M. THOMAS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 6, 1995

Mr. THOMAS. Mr. Speaker, I am pleased today to introduce the Advanced Medical Device Assurance Act of 1995 in order to clarify the scope of coverage and amount of payment under the Medicare Program of items and services associated with the use of certain medical devices approved for investigational use.

Questions have been raised as to whether Medicare should reimburse for hospital and physician services when procedures involving a medical device approved for use by the Federal Drug Administration [FDA] under the Investigational Drug Device [IDE] is used. Our Nation's leading clinical researchers and doctors, and the patients who depend on these improved medical technologies are losing because of this confusion. Additionally, the use of these advanced devices is dramatically declining around the country. Many of the medical technology companies are moving all of their research out of the United States to Europe, Canada, and Japan where payment policy is not an issue.

These advanced medical devices reduce length of surgical procedure, hospitalization, patient mortality, and the need for repeat procedures. All of these patients, whether they get an advanced device or not, would be in the hospital anyway receiving medically indicated care. Clarifying the policy to provide coverage for newer devices would not increase costs because the DRG pays a set rate for set therapies regardless of whether there is a clinical trial involved.

The American Academy of Orthopedic Surgeons, American College of Cardiology, American Hospital Association, American Medical Association, Association of American Medical Colleges, Association of Professors of Medicine, California Health Institute, Catholic Health Association, Cleveland Clinic, Coalition of Boston Teaching Hospitals, Federation of American Health Systems, Greater New York Hospital Association, Health Industry Manufacturers Association, Mayo Clinic, North American Society of Pacing and Electrophysiology, and the Society of Thoracic Surgeons all believe we need to clarify this policy. These are all well-respected health care organizations and I believe this bill brings about the clarity that is needed.

I strongly encourage my colleagues to cosponsor this important, cost-neutral legislation and to work for its prompt enactment so that Medicare beneficiaries will have access to safe and high-quality medical care.

STATEMENT IN RECOGNITION OF 2D LT. REBECCA E. MARIER

HON. SUE W. KELLY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 6, 1995

Mrs. KELLY. Mr. Speaker I rise to acknowledge and salute the outstanding achievements of 2d Lt. Rebecca E. Marier. This impressive young woman recently graduated from the U.S. Military Academy in West Point, NY at the top of her class—top of her class academically, physically, and militarily.

Second Lieutenant Marier opted to forgo an education at prestigious Harvard University, in order to pursue her dream of a degree from an institution which has a proud tradition of molding our Nation's leaders. Marier is unquestionably a role model for all of our Nation's young people, men and women alike.

Mr. Speaker, I ask that you and all my colleagues join me in not only commending Second Lieutenant Marier's achievements, but more importantly her spirit of selfless dedication to the service of our country. I would also ask, Mr. Speaker, that the New York Time's article which appeared this past Sunday, noting Second Lieutenant Marier's achievements, be inserted at this point in the CONGRESSIONAL RECORD.

[From the New York Times, June 4, 1995]

WOMAN IS NO. 1 IN WEST POINT CLASS

WEST POINT, NY—For the first time in the United States Military Academy's 193-year old history, a woman took the No. 1 class rank as the Academy graduated 988 new members of the Army officer corps today.

The woman, Second Lieut. Rebecca E. Marier, 21, of New Orleans, was the head of her class in the school's three programs—military, academic and physical.

''It was the greatest feeling in the world, throwing up that white hat,'' Lieutenant Marier said after the ceremony. ''I'm just glad to be part of the progress women are making all over the country.''

Four years ago, she startled her family and friends by choosing the Academy over Harvard University for her undergraduate work because she wanted the ''all-around challenge'' and leadership training West Point offered.

But she plans to get to Harvard, after all, becoming the second cadet in West Point history to go on to medical school there, said Andrea Hamburger, an Academy spokeswoman.

Women began attending West Point in 1976, and with today's class, more than 1,400 women will have been commissioned second lieutenants.

At the ceremonies, the Army Chief of Staff, Gen. Gordon Sullivan, addressed graduates, telling them that in an age of changing circumstances, there was no way to predict where they might serve.

General Sullivan omitted remarks about a possible United States role in Bosnia, which had appeared in an advance version of his address received by reporters.

In the prepared text, General Sullivan reviewed the American role as a member of NATO and said the United States was ''prepared to act with NATO should the need arise.''

Pressed afterward for an explanation of the omission in his speech, he replied: ''I felt I had made the point of the uncertainty of the world. I didn't think I needed to go into the details.''

General Sullivan's advance text read:

''In response to the appalling Bosnian Serb behavior over the past week, we have been meeting with our NATO allies to consider the next steps to keep the U.N. protection force in place, because it remains our best insurance against an even worse humanitarian disaster there.

''Although our policy remains that we will not become combatants in the conflict, we are prepared to act with NATO should the need arise.''

ACDA IS ESSENTIAL FOR OUR NATIONAL SECURITY

HON. JAMES P. MORAN

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, June 6, 1995

Mr. MORAN. Mr. Speaker, I rise to express my support for the Arms Control and Disarmament Agency as an independent agency and to urge that we consider how important arms control continues to be for our national security. This is also the conclusion of a recent editorial from the News & Observer, from Raleigh, NC. H.R. 1561 would abolish this small federal agency which has proven itself to be an economic bargain. Not only does the operation of the agency come with a modest price tag of under $50 million, its efforts have saved the Government millions, if not billions, of dollars in defense outlays over its 30-plus years of existence.

I urge a ''no'' vote on final passage of H.R. 1561. We should not merge ACDA and the other separate foreign service agencies with separate missions into the State Department. The U.S. ACDA is pursuing the biggest and broadest arms control and nonproliferation agenda in history. As the following article makes clear, now is not the time to be dismantling the agency that is charged with getting these agreements negotiated, implemented and verified.

[From the News & Observer, May 30, 1995]

FOREIGN POLICY MEDDLING

A proposal to reorganize foreign affairs agencies has consequences beyond mere streamlining. Some in Congress would like excessive control over foreign policy, a bad idea in today's unstable world.

Overhauling the nation's foreign policy agencies, as proposed by Senator Helms, seems on first glance to make sense. Separate organizations tend to be inefficient, and as long as the rest of government is being ''reinvested,'' foreign affairs shouldn't be exempt.

But a closer look unveils flaws in the proposal, which is advanced in pending legislation in both the Senate and the House.

For one thing, the assorted foreign services agencies don't all have the same mission; merging them into the State Department risks diluting their influence in the sea of a single mighty bureaucracy. In a recent visit to The N&O, John Holum, director of the Arms Control and Disarmament Agency, made a strong argument along this line for preserving his office as a separate expert voice.

As Holum pointed out, the agency's advocacy of arms control and nonproliferation is crucial in the face of new threats from the spread of weapons. His worry, and it comes across as legitimate, is that the arms-control quest could become secondary to the State Department's concerns for smooth diplomacy and maintaining good relations with other countries.